No. 95-1858

In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL., PETITIONERS

v.

TIMOTHY E. QUILL, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether a State that allows competent, terminally ill persons to refuse life-sustaining medical treatment violates the Equal Protection Clause if it makes it unlawful for physicians to prescribe lethal dosages of medication for use by such persons who request the medication for the purpose of ending their lives.

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INTEREST OF THE UNITED STATES

This case raises the question whether the Equal Protection Clause of the Fourteenth Amendment permits a State to prohibit a physician from prescribing lethal dosages of medication for a competent, terminally ill adult who requests such medication for the purpose of ending his life, while allowing a competent, terminally ill adult to refuse or discontinue artificial life support. The court of appeals concluded that such competent, terminally ill adults are similarly circumstanced and that the State has insufficient justification for distinguishing between the

prescription of lethal medication and the termination of life-sustaining medical treatment, including the withdrawal of hydration, feeding tubes, respirators, and similar devices. See Pet. App. 29a-33a.

The United States owns and operates numerous health care facilities that permit patients to refuse life-sustaining treatment, but do not permit physicians either to administer or to prescribe medications for the purpose of ending a patient's life. For example, the Department of Veterans Affairs (VA) operates 173 medical centers, 126 nursing homes, and 55 in-patient hospices. A VA policy manual generally permits the withholding and withdrawal of life-sustaining treatment in response to a patient's request, but prohibits "the active hastening of the moment of death." Department of Veterans Affairs, Manual M-2 ¶ 31.08(c) (Nov. 1991). Similarly, the VA's hospice program guide states that "[t]he hospice philosophy does not condone nor participate in any action intended to hasten * * * the patient's death." Department of Veterans Affairs, Veterans Health Admin., Program Guide 1140.10: Hospice Program ¶ 1.02(b) (Sept. 1996). A similar practice is followed by the military services, which operate 124 medical centers, the Indian Health Service, which operates 43 hospitals, and the National Institutes of Health, which operate a clinical center.

In addition, Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388-115, requires all health care providers receiving Medicaid or Medicare first, to inform all competent adults about state laws concerning the right of patients to refuse life-sustaining treatment and second, to record any advance directives the patient might have. 42 U.S.C. 1395cc(f). No federal law authorizes or encourages physician assisted suicide.

The United States therefore has a substantial interest in the resolution of the question presented in this case.

STATEMENT

1. Under New York law, "[a] person is guilty of manslaughter in the second degree when * * * [h]e intentionally causes or aids another person to commit suicide." N.Y. Penal Law § 125.15(3) (McKinney 1987). Similarly, he is "guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." *Id.* § 120.30. Three terminally ill patients and three physicians who treat terminally ill patients filed suit in the United States District Court for the Southern District of New York alleging that those statutes violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the extent that they bar physicians from prescribing lethal dosages of medication for mentally competent, terminally ill patients who request this medication for the purpose of ending their lives.

At the time of the filing of the complaint, each of the patient plaintiffs was a mentally competent adult in the final stages of a terminal illness. Patient Jane Doe, a retired teacher, suffered from a thyroid cancer that made it necessary to implant a feeding tube in her stomach; she was unable to reduce her pain to a manageable level. Pet. App. 5a, 7a-8a. Patient George A. Kingsley, a publishing executive, was infected with AIDS and suffered a host of related illnesses, including parasitic infections that caused brain lesions, pain, diarrhea, exhaustion and wasting, and a virus that was robbing him of his sight. *Id.* at 5a, 8a-9a. Patient William A. Barth, a former fashion editor,

also suffered from AIDS and related illnesses, including skin cancer, pneumonia and parasitic infections that caused diarrhea, fevers, wasting and "pain and suffering" that he could "no longer endure." *Id.* at 5a, 9a-10a. Each sought "necessary medical assistance in the form of medications prescribed by [her or his] physician" in order to hasten death "in a certain and humane manner." *Id.* at 5a. Each died before the district court ruled on their motion for a preliminary injunction.

The physician plaintiffs alleged that they treated "mentally competent, terminally ill patients" who "experience[d] chronic, intractable pain and/or intolerable suffering." Pet. App. 5a. They alleged that, under certain circumstances, it would be consistent with the standards of medical practice to prescribe medications that these patients could self-administer in order to hasten death. *Ibid.*

The district court dismissed plaintiffs' claims. Pet. App. 63a-78a. It rejected their due process claim on the grounds that there was no fundamental liberty interest in physician assisted suicide. *Id.* at 76a. It then rejected their equal protection claim, finding a reasonable and rational basis to distinguish between the right to refuse medical treatment and the claimed right to physician assistance in committing suicide. Citing the State's interests "in preserving life, and in protecting vulnerable persons," as well as the State's "further right to determine how these crucial interests are to be treated," the court found it "hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Id.* at 77a.

2. a. The court of appeals reversed. Pet. App. 1a-62a. The court found no substantive due process violation, concluding that the New York statutes do not infringe any fundamental liberty interest because assisted suicide is neither "so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed" nor "deeply rooted in the nation's traditions and history." *Id.* at 18a. The court held, however, that the statutes violate the Equal Protection Clause "because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." *Id.* at 35a. It concluded that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Id.* at 29a-30a.

The court found no legitimate state interest to support this difference in treatment. See Pet. App. 31a-34a. It dismissed the argument that the refusal of treatment allows a "natural" death or requires less action by the physician. *Id.* at 30a-31a. It then rejected the State's asserted interest in "preserving the life of all its citizens at all times and under all conditions," suggesting that this interest "lessens as the potential for life diminishes," and that the State has no interest in "requir[ing] the continuation of

agony when the result is imminent and inevitable." *Id.* at 31a.

Finally, the court concluded that the New York statutes do not serve any of the state interests identified by the Ninth Circuit panel in *Compassion in Dying* v. *Washington*, 49 F.3d 586 (1995), on reh'g en banc, 79 F.3d 790 (1996), cert. granted *sub nom. Washington* v. *Glucksberg*, No. 96-110 (Oct. 1, 1996). See Pet. App. 32a-34a. Those interests include preserving the role of physicians as healers, not killers; "avoiding psychological pressure upon the elderly and infirm to consent to death"; "preventing the exploitation of the poor and minorities"; "protecting handicapped persons against societal indifference"; "preventing the sort of abuse" found in the Netherlands, where physician assisted suicide is permitted and euthanasia occurs;[1] and avoiding difficulties that arise from the lack of a clear definition of the "terminally ill." *Id.* at 32a.

b. Judge Calabresi concurred in the result. Pet. App. 35a-62a. He concluded that, while the statutes still "nominally * * * forbid[]" physician assisted suicide, "the bases of these statutes have been deeply eroded over the last hundred and fifty years" and "few

[1] It is important to keep in mind the distinctions among (1) a patient's decision to decline or terminate unwanted medical treatment, including nutrition and hydration, even where that treatment may be necessary to sustain life; (2) the prescription by a physician of a lethal dosage of medication, to be self-administered by the patient, which is what is generally meant by the term "physician assisted suicide"; and (3) the administration by a physician of a lethal medication, referred to as "euthanasia." This case concerns only the second of these scenarios: physician-provided lethal medication. See Pet. App. 4a, 35a.

of their foundations remain in place today." *Id.* at 43a. Citing the "constitutional dubiety" of those statutes, he concluded that they could be upheld only on the basis of a "present and positive acknowledgment" by the legislature of the state interests at stake. *Id.* at 45a.

Based on his conclusion that the legislature "for many, many years * * * ha[d] not taken any recognizably affirmative step reaffirming the prohibition of what [respondents] seek," Pet. App. 44a, he would have held that, "on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment * * * to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness," *id.* at 62a. Judge Calabresi declined, however, to take a position on "whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves." *Ibid.*

SUMMARY OF ARGUMENT

A state legislature, seeking to balance respect for individual patients' wishes against the protection of many patients' lives, may conclude that extremely important state interests justify a distinction between the refusal of unwanted medical treatment and the prescription of lethal dosages of medication for the purpose of ending life. Those interests include

preserving the distinction between killing a patient and letting a patient die; preventing the deaths of persons who are erroneously diagnosed as terminally ill; prohibiting a practice that is vulnerable to abuse or error and extremely difficult to police; and avoiding the greatest intrusions upon a patient's bodily integrity. Thus, a State does not violate the Equal Protection Clause of the Fourteenth Amendment by allowing a doctor to honor patients' directives to discontinue life-sustaining medical treatment while prohibiting a doctor from prescribing lethal dosages of medication for patients who request this medication for the purpose of ending their lives.

ARGUMENT

I. A STATE MAY CONCLUDE THAT IMPORTANT STATE INTERESTS JUSTIFY PROHIBITING PHYSICIAN ASSISTED SUICIDE WHILE PERMITTING THE REFUSAL OF MEDICAL TREATMENT

1. The Equal Protection Clause of the Fourteenth Amendment directs that "all persons similarly circumstanced shall be treated alike." *Plyler* v. *Doe*, 457 U.S. 202, 216 (1982) (quoting *F.S. Royster Guano Co.* v. *Virginia*, 253 U.S. 412, 415 (1920)). The Constitution does not, however, "require things which are different in fact or opinion to be treated in law as though they were the same," *ibid.* (quoting *Tigner* v. *Texas*, 310 U.S. 141, 147 (1940)), and a legislature must have some "latitude" in creating classifications that respond to perceived problems and "accommodate competing concerns both public and private," *ibid.*

In finding no rational basis for distinguishing between a patient's refusal of medical treatment and a physician's prescription of a lethal drug for the

purpose of helping a patient commit suicide, see Pet. App. 24a-25a, the court of appeals overlooked extremely important state interests offering substantial justification for this distinction. The gravity and magnitude of the harms that could accompany the prescription of lethal medication are such that a responsible, compassionate state legislator who took full account of the important liberty interest of a terminally ill person in avoiding protracted severe pain or suffering could still conclude that a prohibition on this practice was necessary to guard against those harms.

2. As we develop more fully in our amicus brief (at 16-24) in *Washington* v. *Glucksberg*, No. 96-110, at this point in our history, a state legislature could responsibly conclude that making physician assisted suicide available for some "would create widespread and unjustified risks for many others." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 135 (May 1994) (*Task Force Report*). Those dangers include the deaths of many persons who are not competent, not terminally ill, and not truly ready to die, but who are steered toward suicide by a confluence of forces, including a health care system that often undertreats patients' pain and depression; physicians who cannot or do not take the time to explore their patients' fears about the course of their illness and to reassure them of continued support; family members who are exhausted by the ordeal of a lingering illness; a mistaken diagnosis or prognosis; or the patients' own fears of being a "burden" to their loved ones or society.

3. Undoubtedly, some of these dangers also attend the decision to withhold or withdraw medical treat-

ment. In other respects, however, a legislature confronts weighty practical differences in terms of the dangers each practice poses to the lives and welfare of the State's citizens. Harms that arise from physician prescribed lethal medication often differ in kind or degree from those that result from patient refusal of medical treatment. Those harms include the erosion of the distinction between killing and letting die; the far more serious consequence of an erroneous diagnosis of a terminal illness; and the far greater number of persons whose lives could be shortened through error or undue influence. Also supporting the distinction between the two practices is the often invasive nature of life support.

a. The principal distinction between providing a patient lethal medication and allowing a patient to refuse treatment is the widely accepted distinction between killing and letting die. To let a patient die is to acknowledge the futility of further medical treatment and to let nature run its course. Death results from the underlying fatal pathology of the patient's disease or disorder, not from the independent action of the physician. Physician prescribed lethal medication, in contrast, provides its own fatal pathology. There is, in short, "a fundamental difference between what nature does to us and what we do to one another." Daniel Callahan, *The Troubled Dream of Life* 76 (1993). That intuitive distinction, which comports with our common experience, is reflected in state law and medical practice. See 96-110 Pet. App. A68 & n.77 (listing States that permit the withdrawal of life-sustaining treatment); *id.* at A135-A136 (listing States that prohibit assisted suicide); see also *Thor* v. *Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("[A] necessary distinction exists between a person suffering from a serious life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her own demise and attempts to enlist the assistance of others."); *McKay* v. *Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) (recognizing a "substantial difference" between "non-interference with the natural consequences of [a patient's] condition" and a patient's "terminat[ing] his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient [or physician].").

Underlying this distinction are important ethical considerations about the physician's professional responsibility to do no harm. The medical profession recognizes ethical distinctions between discontinuing unwanted, futile treatments and "using the tools of medicine to cause a patient's death." Council on Ethical and Judicial Affairs, American Medical Ass'n, *Decisions Near the End of Life*, 267 J. Am. Med. Ass'n 2229, 2230-2231, 2233 (1992); see Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, Am. Med. News, Dec. 20, 1993 at 7; Willard Gaylin, et al., *Doctors Must Not Kill*, 259 J. Am. Med. Ass'n 2139 (1988); Mildred Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14, 17 (Jan. 1993). A State legitimately can assert an interest in preserving this boundary; allowing physicians to participate in suicide could erode public confidence in the profession

and undermine patients' trust in their doctors. See Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 824 (1994) (that few people "may find medical professionals willing and able to ratify and to assist in * * * [suicide] is easily outweighed by the distrust and acute ambivalence engendered in the majority by assigning such a disparate role to an unwilling profession"). The prohibition on assisting suicide erects an important psychological barrier for the physician who might be tempted to resort to a quick exit for the patient whose illness he cannot cure. Moreover, reasonable legislators could fear that legalizing assisted suicide "[c]ould have a subtle but widespread impact on society" by sending the message that society does not value each of its members. *Task Force Report* 101-102.

It is true that a patient's right to terminate his treatment allows him in some circumstances to enlist the assistance of a physician to exercise that right, for example, by removing a feeding tube. It also is true that the removal of a feeding tube requires greater physician involvement and greater bodily intrusion than what respondents seek here. But the distinction between killing and letting die rests on the underlying cause of the patient's death, not on the mere involvement of a physician. With the removal of the feeding tube, the cause of death (assuming the patient dies) is the underlying illness that robbed him of his ability to eat; the physician's removal of the feeding tube lets that illness run its course. With the provision of lethal medication, the physician provides the cause of the patient's death. While this distinction may not be satisfying in all respects, it is workable, and it is grounded in moral and ethical considerations that the State has an interest in preserving. Moreover, as we develop more fully in our amicus brief (at 22-24) in *Washington* v. *Glucksberg*, No. 96-110, permitting the prescription of lethal medication, but attempting to limit it to the terminally ill and to avoid euthanasia, presents equally problematic distinctions and far greater risks. See generally Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 6, 63-64 (1996) (Callahan & White); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on* Roe, Casey, *and the Right to Die*, 44 Am. U. L. Rev. 803, 820-824 (1995); Timothy Quill, et al., *Care of the Hopelessly Ill—Proposed Clinical Criteria For Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380, 1381 (1992); 96-110 Pet. App. A100-A101 (Ninth Circuit, sitting en banc, acknowledging the difficulty of maintaining any distinction between physician–prescribed and physician–administered medication).

b. Also reinforcing the current distinction between physician assisted suicide and the refusal of medical treatment is the State's undeniable interest in preventing the death of persons who are erroneously diagnosed as terminally ill. Predicting a patient's life expectancy is difficult and uncertain. See, *e.g.*, Joanne Lynn, et al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 W. J. Med. 250, 251 (1995). "A surprising number of people have had the experience of being misinformed that they had a terminal illness." Richard A. Posner, *Aging and Old Age* 245 (1995). "[Physician] assisted suicide leave[s] no opportunity to recognize or correct a diagnosis that is negligently provided, or

provided competently, but proves incorrect over time." *Task Force Report* 131. By contrast, the termination of life-sustaining medical treatment for a person wrongly believed to be dependent on such treatment does not result in certain death. Karen Ann Quinlan, for example, lived for years after her life support was disconnected. See George J. Annas, *The "Right to Die" in America: Sloganeering from* Quinlan *and* Cruzan *to* Quill *and* Kevorkian, 34 Duq. L. Rev. 875, 881 n.13 (1996).

c. Refusal to permit physician assisted suicide may also be justified by the predictable difficulty of regulating and limiting such assistance, particularly when it could be offered to all terminally ill persons, or even all members of society. The privacy that appropriately cloaks the doctor-patient relationship could lead thoughtful legislators to conclude that "the nature of the doctor-patient relationship and of the medical procedures themselves renders them resistant to * * * 'clear criteria, rigorous procedures, and adequate safeguards.'" Callahan & White, 30 U. Rich. L. Rev. at 2 (quoting Franklin Miller, et al., *Regulating Physician-Assisted Suicide*, 331 New Eng. J. Med. 119, 120 (1994)). While permitting patients to decline life-sustaining treatment admittedly creates some of the same risks, those risks are limited to an identifiable, self-contained class of persons—those who cannot live without the treatment—many of whom are in hospitals or nursing homes, where their care may be supervised by others. See *Task Force Report* 74; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* 17-18 (Mar. 1983). A legislature reasonably could decide to entrust state regulators, professional organizations, and institutional review boards with the admittedly difficult task of regulating to avoid error and abuse with regard to this group of patients, without having sufficient confidence that they could perform the same task with regard to the vast number of patients who could seek physician assisted suicide.

d. The invasiveness of some compelled life-sustaining treatment presents another legitimate basis for allowing patients to decline it, even while prohibiting physician assisted suicide. As one commentator described it, to be forced to receive life-sustaining treatment "is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery," with his body "so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency." Jed Rubenfeld, *The Right to Privacy*, 102 Harv. L. Rev. 737, 795 (1989). To deny physician assistance in committing suicide is to foreclose one humane and certain route of escape from pain and suffering, but it does not subject a person to nearly the same degree of intrusion and restraint as requiring a person to submit to unwanted medical treatment.

Taken together, these public policy considerations provide substantial justification for prohibiting physician prescribed lethal medication while permitting patient refusal of medical treatment. The court of appeals therefore erred in concluding that the State's interests in preserving this distinction were "[n]one." Pet. App. 31a.

II. THE NEW YORK STATUTORY PROHIBITION OF ASSISTED SUICIDE SUFFICIENTLY REFLECTS A CONTEMPORARY LEGISLATIVE JUDGMENT

Similarly, Judge Calabresi erred in concluding that New York has made no contemporary assertion of the prohibition against assisted suicide. He argued that the statutes criminalizing assisted suicide are anachronisms "born in another age" when suicide itself was a crime and that the New York legislature has retained them through inertia, failing to make any actual, considered legislative judgment to continue those proscriptions or to articulate the state justifications for them. Pet. App. 38a, 57a. That view overlooks significant developments in New York law.

1. Suicide or attempted suicide has not been a crime in New York since 1919. Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193. In 1965, the New York legislature deleted the statutory declaration that suicide is a "grave public wrong." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 1544 (codified at N.Y. Penal Law § 35.10(4) (McKinney 1987)). At that time, the legislature reasserted the criminal prohibitions against intentionally causing or aiding a suicide or attempted suicide—the statutory provisions at issue here. See N.Y. Penal Law §§ 120.30, 125.15(3) (McKinney 1987). That reflects, at the very least, not inertia, but rather a legislative judgment to continue the criminal prohibition against assisting suicide while deleting condemnation of the suicide itself.

2. Since 1965, the New York legislature has adopted legislation giving force to a patient's common law right to refuse medical treatment, but preserving the distinction between refusing unwanted medical treatment on the one hand and assisted suicide or euthanasia on the other. In 1987, the legislature enacted a statute permitting a competent adult to create an order not to resuscitate, or administer cardiopulmonary resuscitation (CPR), in the event that the person suffered cardiac or respiratory arrest. Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 1526 (codified as amended at N.Y. Pub. Health Law §§ 2960-2979 (McKinney 1993 & Supp. 1996)). The legislature adopted that measure in response to a 1986 report and recommendation by the New York State Task Force on Life and the Law. See *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (Apr. 1986). After acknowledging distinctions between the common law right to refuse treatment (to which the legislature was giving effect) and suicide (which the State has an interest in preventing), the Task Force noted that the State's interest in preserving life gave way in the case of orders not to resuscitate primarily because of the highly invasive nature of CPR. *Id.* at 15.

In 1990, the legislature sought further to protect the patient's right to decline unwanted treatment by allowing persons to direct the withholding of life-sustaining treatment through health care proxies and the appointment of health care agents. Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The legislature again acted at the recommendation of the Task Force. See New York State Task Force on Life and the Law, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (July 1987). The Task Force's report accompanying its proposed legislation included

a thoughtful discussion of the need to preserve the distinction between "killing" and "letting die." See *id.* at 36-42. The legislature went a step further, incorporating into the statute an express caveat preserving that distinction:

> This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law.

N.Y. Pub. Health Law § 2989(3) (McKinney 1993). Thus, the legislature, in the context of respecting patients' liberty interests in determining the course of their medical treatment, consciously reinforced the line between the permissible withdrawal of life-sustaining treatment and the prohibited assistance of suicide. That recent legislative reaffirmance of this well-established and widely-accepted line convincingly answers Judge Calabresi's assertion that the distinction has endured merely through legislative inertia.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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